

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
04191											
CERTIFICATE OF DEATH											
04190											
1. PLACE OF DEATH a. COUNTY <b>Saint Mary's</b> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Saint Mary's</b>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Leonardtown</b>				c. LENGTH OF STAY IN 1b <b>3 1/2 weeks</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>St. Inigoes</b>				18-1	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Saint Mary's Hospital</b>						d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Birdine</b>			4. DATE OF DEATH Month Day Year <b>March 19 19 67</b>								
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-19-67</b>		9. AGE (In years last birthday) yrs. <b>3</b>		IF UNDER 1 YEAR Months Days Hours Min. <b>3 20</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?		
13. FATHER'S NAME <b>Ernest Spence</b>						14. MOTHER'S MAIDEN NAME <b>Shirley Ann Birdine</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT <b>Mother</b>			Address <b>St. Inigoes, Md.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Atelectasis</b> <b>7625</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pneumonia</b> DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <b>19 MAR</b> , 19 <b>67</b> , to <b>20 MAR</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>20 MAR</b> 19 <b>67</b> , and that death occurred at <b>3 AM</b> , from the causes and on the date stated above.											
22a. SIGNATURE <b>Milford E. Thurford</b>						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>3/22/67</b>			
22c. PHYSICIAN'S NAME (Type) <b>MILFORD M.D.</b>						22d. ADDRESS <b>MECHANICSVILLE, MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE THEREOF <b>3/27/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ST. ALOYSIUS CEMETERY</b>			23d. LOCATION (City, town or county) (State) <b>LEONARDTOWN, MARYLAND</b>			
24. FUNERAL DIRECTOR <b>W. CLARKE MATTINGLEY</b>						ADDRESS <b>LEONARDTOWN, MARYLAND</b>		25a. REC'D BY REGISTRAR <b>MAR 28 1967</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04192

04191

1. PLACE OF DEATH a. COUNTY <u>St. Mary's</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural California</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural California</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <u>Star Route Box 500</u>			
3. NAME OF DECEASED (Type or print) First <u>Lucy</u> Middle <u>E.</u> Last <u>Combs</u>				4. DATE OF DEATH Month <u>March</u> Day <u>8</u> Year <u>1967</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 9, 1879</u>	9. AGE (In years last birthday) <u>87</u> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 24 HRS. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas B. Abell</u>				14. MOTHER'S MAIDEN NAME <u>Ananda Dorsey</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs Elizabeth C. Bean</u> Address <u>same as # 2 above</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro Vascular Accident</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arterio Sclerosis</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>10 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>58</u> , to <u>March 8</u> , 19 <u>67</u> , that (I) (we) last saw the deceased alive on <u>March 7</u> , 19 <u>67</u> , and that death occurred at <u>9 A</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>William D. Boyd</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>William D. Boyd M.D.</u>				22d. ADDRESS <u>Leonardtown, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>March 11, 1967</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Johns Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Hollywood, Maryland</u>	
24. FUNERAL DIRECTOR <u>W. Clarke Mattingley</u>				25. REC'D BY REGISTRAR DATE <u>MAR 13 1967</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

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*Journal of Management Education* 30(6)



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04194

CERTIFICATE OF DEATH

04193

1. PLACE OF DEATH a. COUNTY <u>St. Mary's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Mechanicsville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Mechanicsville</u>	
c. LENGTH OF STAY IN TB <u>43 years</u>		18-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <u>Route 1 box 119</u>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Carrie Lotetta Cheseldine Dixon</u>		4. DATE OF DEATH Month <u>March</u> Day <u>19</u> Year <u>1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 7, 1893</u>
9. AGE (In years last birthday) <u>73</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Seneca Cheseldine</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ellen (Nellie) Norris</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Edgar S. Dixon</u>		Address <u>same as # 2 above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac decompensation</u> DUE TO (b) <u>Hypertensive arteriosclerotic CVD</u> DUE TO (c) <u>13 yrs</u>		INTERVAL BETWEEN ONSET AND DEATH <u>30 min</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>48</u> , to <u>Mar 19</u> , 19 <u>67</u> , that (II) (we) last saw the deceased alive on <u>Mar 19</u> , 19 <u>67</u> , and that death occurred at <u>11</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Key Lupton</u>		22b. DATE SIGNED <u>3-20-67</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <u>Mechanicsville, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>3/22/67</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Sacred Heart Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Bushwood Maryland</u>	
24. FUNERAL DIRECTOR <u>W. Clarke Mattingley</u>		25a. REC'D BY REGISTRAR <u>MAR 23 1967</u>	
ADDRESS <u>Leonardtown, Maryland</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #12 Film #G387 4/3/67 pc

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>St. Mary's</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural Valley Lee</b>			c. LENGTH OF STAY IN b <b>Andover Estates</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Edge of St. Georges Creek</b>			d. STREET ADDRESS <b>Valley Lee Andover Estates</b>		
3. NAME OF DECEASED (Type or print) First <b>PATRICIA</b> Middle <b>HELEN</b> Last <b>GILLIAN</b>			4. DATE OF DEATH Month <b>March</b> Day <b>23</b> Year <b>19 67</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 22, 1935</b>	9. AGE (In years last birthday) <b>31</b> yrs.	IF UNDER 1 YEAR Months <b>23</b> Days <b>19</b> Hours <b>67</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>At Home</b>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Canada</b>		12. CITIZEN OF WHAT COUNTRY? <b>Canada</b>
13. FATHER'S NAME <b>Harry B. Wills</b>			14. MOTHER'S MAIDEN NAME <b>Winifred McDonald</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>008-26-0003</b>	17. INFORMANT <b>Robert Gilligan</b> Address <b>Same as 2 above</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Exsanguination</b> DUE TO <b>977X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Bilateral Wrist Lacerations.</b> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Slashed wrists.</b>			
20c. TIME OF INJURY Month, Day, Year Hour <b>3:00</b> p.m. <b>3/ 22 1967</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Near Home</b>	20f. (City or town) (County) (State) <b>Andover Estates St. Mary's</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Charles S. Petty</b>		M.D.		22. DATE SIGNED <b>3/24/67</b>	
EXAMINER'S NAME (Type) <b>Charles S. Petty</b>		Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>MARCH 29, 1967</b>	23c. NAME OF CEMETERY OR CREMATORY <b>HOLY CROSS CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>ST ALBANS TOWN, VT.</b>	
24. FUNERAL DIRECTOR <b>W. CLARKE MATTINGLEY</b>			ADDRESS <b>LEONARDTOWN, MARYLAND</b>		25a. REC'D BY REGISTRAR <b>MAR 28 1967</b>
			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

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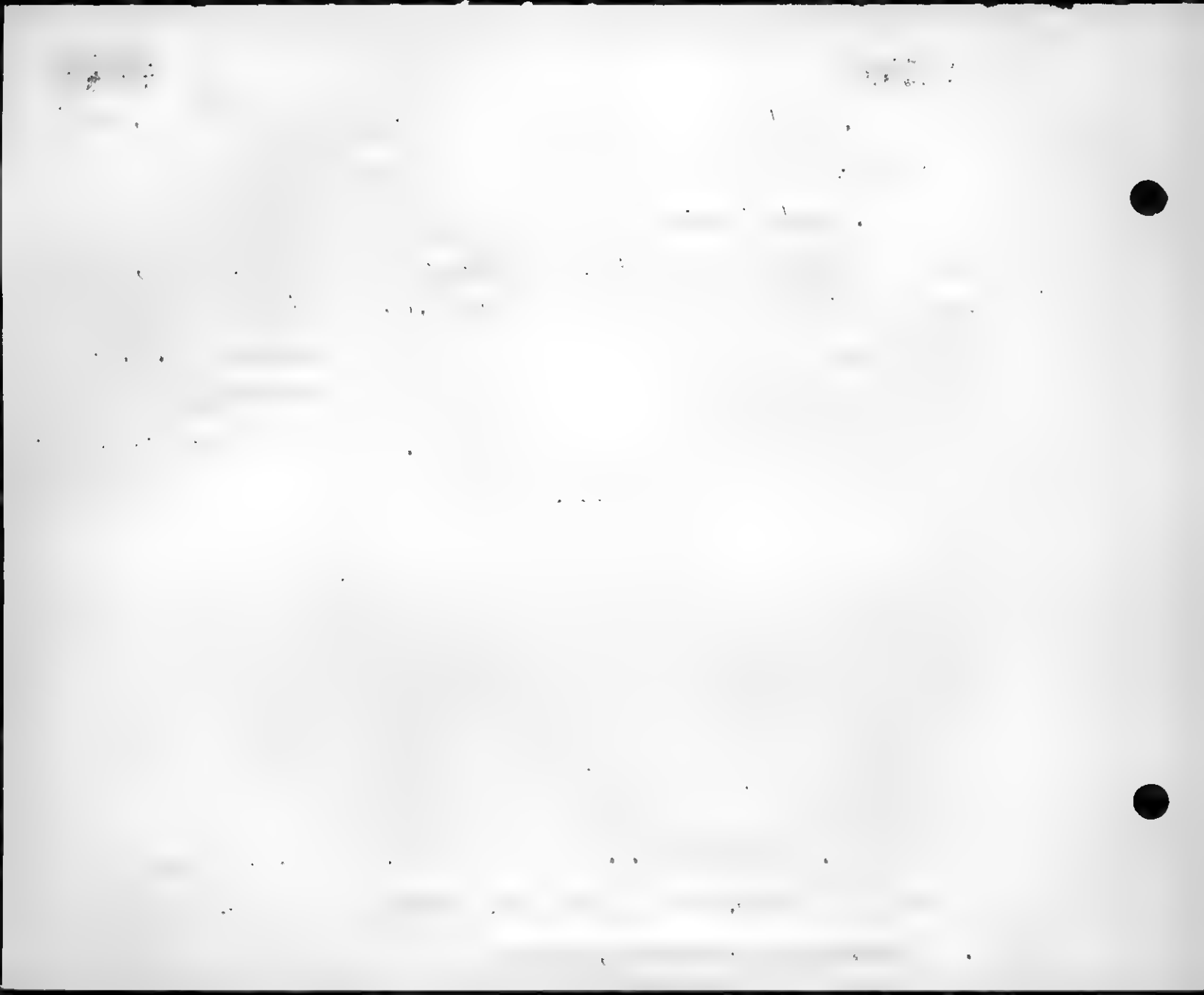
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<div style="display: flex; justify-content: space-between;"> <div> <p>MARYLAND STATE DEPARTMENT OF HEALTH</p> <p>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> <p><b>04196</b></p> </div> <div style="text-align: center;"> <p><b>CERTIFICATE OF DEATH</b></p> </div> <div> <p><b>04195</b></p> </div> </div>											
<p>1. PLACE OF DEATH</p> <p>a. COUNTY <i>St. Mary's</i> MARYLAND</p>					<p>2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)</p> <p>a. STATE <i>Maryland</i> b. COUNTY <i>St. Mary's</i></p>						
<p>b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)</p> <p><i>Leonardtoun</i></p>			<p>c. LENGTH OF STAY IN 1b</p> <p><i>3 days</i></p>		<p>c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)</p> <p><i>Maddox</i></p>						
<p>d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)</p> <p><i>St. Mary's Hospital</i></p>					<p>d. STREET ADDRESS</p>			<p>e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>			
<p>3. NAME OF DECEASED (Type or print)</p> <p>First <i>Mabel</i> Middle <i>Elizabeth</i> Last <i>Graves</i></p>					<p>4. DATE OF DEATH</p> <p>Month <i>March</i> Day <i>5</i> Year <i>1967</i></p>						
<p>5. SEX</p> <p><i>Female</i></p>		<p>6. COLOR OR RACE</p> <p><i>White</i></p>		<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH</p> <p><i>June 9, 1912</i></p>		<p>9. AGE (in years last birthday)</p> <p><i>54</i> yrs.</p>			
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p> <p><i>at home</i></p>				<p>10b. KIND OF BUSINESS OR INDUSTRY</p>		<p>11. BIRTHPLACE (County &amp; State, or foreign country)</p> <p><i>Maryland</i></p>		<p>12. CITIZEN OF WHAT COUNTRY?</p> <p><i>U. S. A</i></p>			
<p>13. FATHER'S NAME</p> <p><i>William Jenkins Hayden</i></p>					<p>14. MOTHER'S MAIDEN NAME</p> <p><i>Rose Gwynette Morgan</i></p>						
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)</p>				<p>16. SOCIAL SECURITY NO.</p>		<p>17. INFORMANT</p> <p><i>Laurence K. Graves</i></p>		<p>Address</p> <p><i>Maddox, Maryland</i></p>			
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]</p> <p>PART I. DEATH WAS CAUSED BY:</p> <p>IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i></p> <p>DO TO</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Atherosclerotic cardiovascular</i></p> <p>DO TO (c) <i>Diabetes mellitus</i></p>								<p>INTERVAL BETWEEN ONSET AND DEATH</p> <p><i>3 d.</i></p>			
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</p>											
<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p>				<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)</p>							
<p>20c. TIME OF INJURY</p> <p>Month, Day, Year</p> <p>Hour a.m. p.m.</p> <p><i>19</i></p>			<p>20d. INJURY OCCURRED</p> <p>While at work <input type="checkbox"/> Not While at work <input type="checkbox"/></p>		<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>		<p>20f. (City or town) (County) (State)</p>				
<p>21. I certify that (I) (this hospital) attended the deceased from <i>Jan</i>, 1962, to <i>Mar 5</i>, 1967, that (I) (we) last saw the deceased alive on <i>Mar 5</i>, 1967, and that death occurred at <i>M</i>, from the causes and on the date stated above.</p>											
<p>22a. SIGNATURE</p> <p><i>J. Roy Guyther</i></p>					<p>22b. DATE SIGNED</p>			<p>22c. PHYSICIAN'S NAME (Type)</p> <p><i>J. Roy Guyther, M.D.</i></p>			
<p>22d. ADDRESS</p> <p><i>Mechanicville, Maryland</i></p>					<p>22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/></p>						
<p>23a. BURIAL, CREMATION, REMOVAL (Specify)</p> <p><i>Burial</i></p>		<p>23b. DATE THEREOF</p> <p><i>March 8, 1967</i></p>		<p>23c. NAME OF CEMETERY OR CREMATORY</p> <p><i>Sacred Heart Cemetery</i></p>			<p>23d. LOCATION (City, town or county) (State)</p> <p><i>Bushwood, Maryland</i></p>				
<p>24. FUNERAL DIRECTOR</p> <p><i>W. Clarke Mattingley Leonardtoun, Maryland</i></p>					<p>25a. REC'D BY REGISTRAR</p> <p><i>MAR 10 1967</i></p>					<p>25b. REGISTRAR'S SIGNATURE</p> <p><i>J. Charles Judge</i></p>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

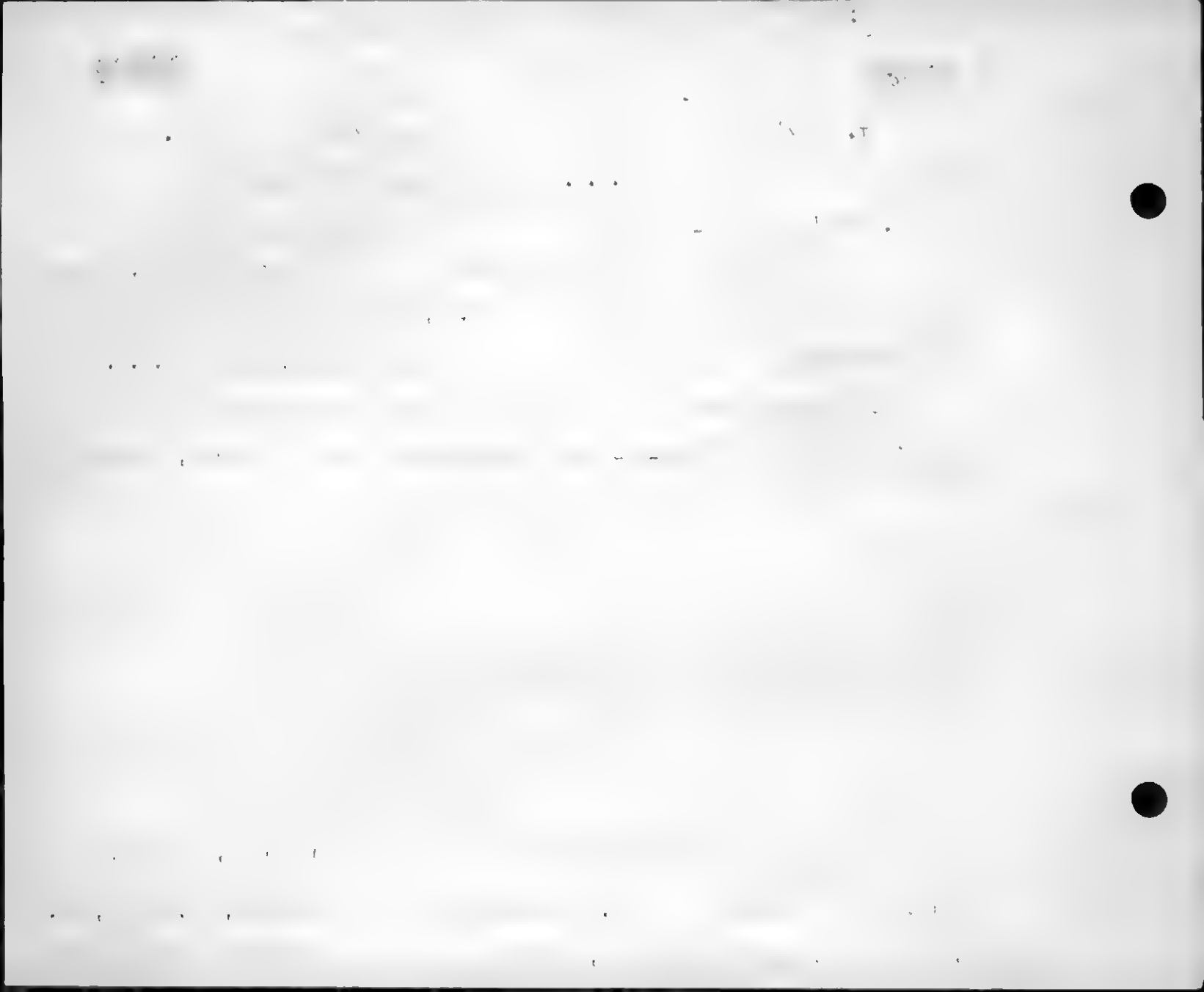
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04197

CERTIFICATE OF DEATH

04196

1. PLACE OF DEATH a. COUNTY <b>ST. MARY'S</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ST. MARY'S</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LEONARDTOWN</b>				c. LENGTH OF STAY IN 1b <b>D.O.A.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>ST. MARY'S HOSPITAL</b>				d. STREET ADDRESS <b>RURAL CHAPTICO</b>			
3. NAME OF DECEASED (Type or print) First <b>ALBERT</b> Middle <b>JOSEPH</b> Last <b>GRAY</b>				4. DATE OF DEATH Month <b>MARCH</b> Day <b>13</b> Year <b>1967</b>			
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>DEC. 9, 1907</b>	
9. AGE (in years last birthday) <b>59</b> yrs		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CIVIL SERVICE</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>CHARLES McKENNY GRAY</b>		14. MOTHER'S MAIDEN NAME <b>LUCY ANN PILKERTON</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>W W 11</b>		16. SOCIAL SECURITY NO <b>220-16-4457</b>		17. INFORMANT <b>IDA ELIZABETH GRAY</b> Address <b>CHAPTICO, MARYLAND</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> 4201 DUE TO <b>ASCVD</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>4 hrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>July, 1955</b> to <b>Mar, 1967</b> , that (I) (we) last saw the/deceased alive on <b>Feb 19 67</b> , and that death occurred at <b>5</b> M, from causes and on the date stated above.							
22a. SIGNATURE <b>Leon B. Berube</b>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>Leon B. Berube M.D.</b>				22d. ADDRESS <b>MECHANICSVILLE, MARYLAND</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>3/16/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ST. JOSEPH'S CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>MORGANZA, ST. MARY'S, MD.</b>	
24. FUNERAL DIRECTOR <b>W. CLARKE MATTINGLEY</b> <b>LEONARDTOWN, MARYLAND</b>				25a. REC'D BY REGISTRAR <b>DAF 16 1967</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

04198		04197	
1. PLACE OF DEATH a. COUNTY ST. MARY'S b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) LEONARDTOWN c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) ST. MARY'S HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY ST. MARY'S c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) (RURAL) ST. MARY'S CITY d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ANDREW NIM GRESKO		4. DATE OF DEATH Month Day Year MARCH 31 1967	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 15, 1884 9. AGE (in years last birthday) 83 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARMING	
11. BIRTHPLACE (County & State, or foreign country) CZECKO SLOVAKIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME JOHN GRESKO		14. MOTHER'S MAIDEN NAME MARY LIPTAK	
15. WAS DECEASED EVER IN U.S. ARMY FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 17. INFORMANT SUE G. ROSKOS Address ST. MARY'S CITY, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 200. Lymphosarcoma abdominal glands DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from June 1965, to March 1967, that (I) (we) last saw the deceased alive on 19, and that death occurred at M, from the causes and on the date stated above.			
22a. SIGNATURE DR. P. J. BEAN, M.D.		22b. DATE SIGNED April 1/67 M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS GREAT MILLS, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF APRIL 3, 1967	
23c. NAME OF CEMETERY OR CREMATORY EBELEZER CEMETERY		23d. LOCATION (City, town or county) (State) GREAT MILLS, MARYLAND	
24. FUNERAL DIRECTOR JOHN M. WELCH		25. REGISTRAR'S SIGNATURE Charles Judge APR 5 1967 DATE	



FOR STATE  
HEALTH DEPT.

04199

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

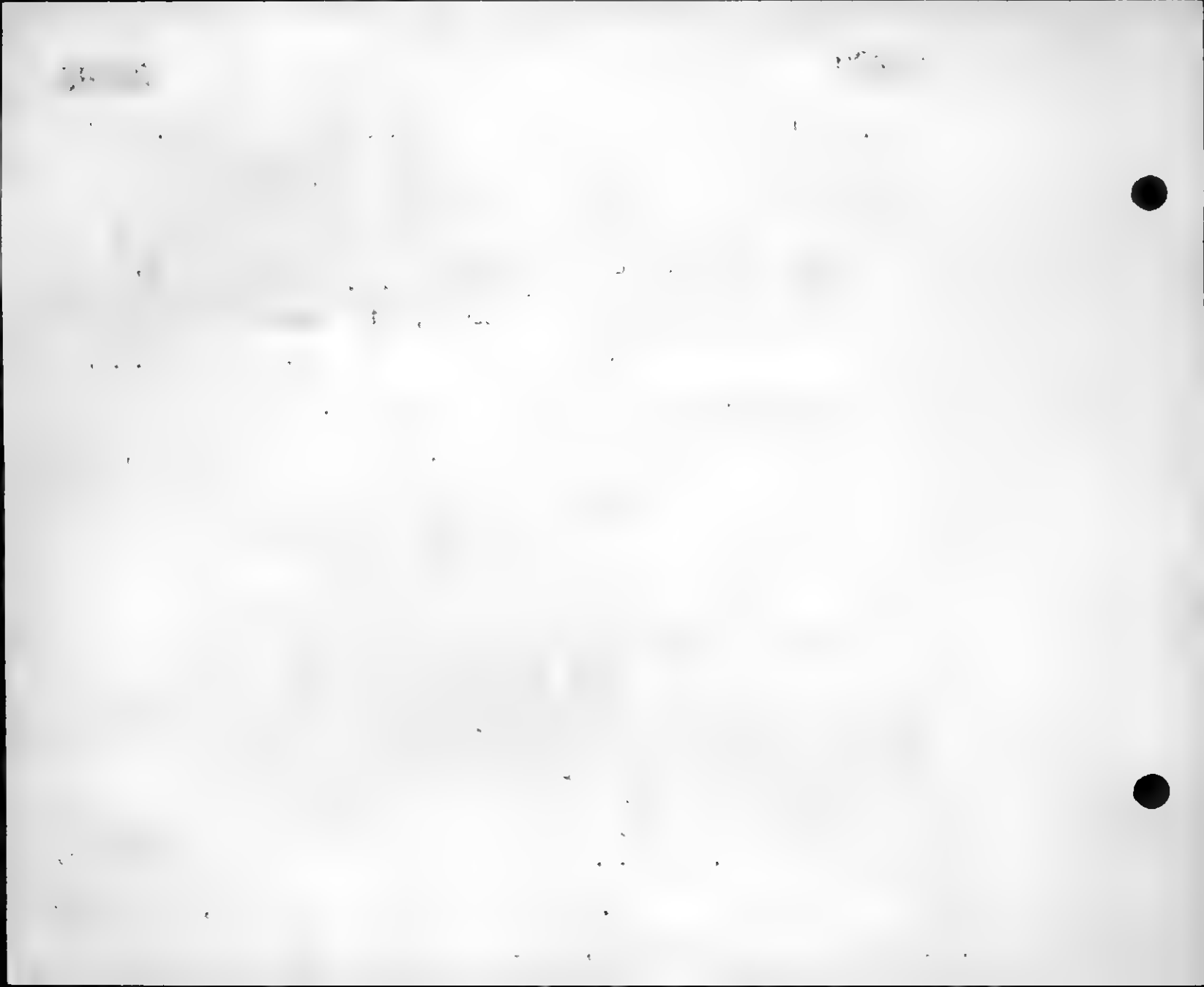
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04198

1 PLACE OF DEATH a. COUNTY <b>ST. MARY'S</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived if insttut on Res denre before admiss on) a. STATE <b>MARYLAND</b> b. COUNTY <b>ST. MARY'S</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LEXINGTON PARK</b>		c. LENGTH OF STAY IN Td <b>LIFE</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		d. STREET ADDRESS <b>RURAL LEXINGTON PARK</b>	
e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) <b>JOHN SAMEUL JOHNSON</b>		4 DATE OF DEATH <b>MARCH 24, 1967</b>	
5 SEX <b>MALE</b>	6 COLOR OR RACE <b>NEGRO</b>	7 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>1941 JULY 24, 1941</b>
9 AGE (In years last birthday) <b>25 yrs</b>		10 FUND 1 YEAR <input type="checkbox"/> IF UNDER 24 HRS <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>DAY</b>	
11 BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12 CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOSEPH SOMERVILLE</b>		14. MOTHER'S MAIDEN NAME <b>JULIE E. JOHNSON</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO <b>213-40-6324</b>	
17. INFORMANT <b>JULIA E. JOHNSON</b>		Address <b>LEXINGTON PARK, MARYLAND</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>8124</b> IMMEDIATE CAUSE (a) <b>Laceration spinal cord</b> DUE TO (b) <b>Fracture cervical vert.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)			INTERVAL BETWEEN ONSET AND DEATH <b>immed</b> <b>immed</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Fracture rt femur + left Tibia + fibula</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1B) <b>Hit by auto -</b>	
20c. TIME OF DEATH Month, Day, Year <b>10:15 p.m. 3-24 1967</b>		20d. NATURE OF INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg, etc.) <b>Route 235</b>		20f. (City or town) (County) (State) <b>Lexington Park St Mary's Md</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>William D. Boyd M.D.</b>		22. DATE SIGNED <b>3/25/67</b>	
EXAMINER'S NAME (Type) <b>WILLIAM D. BOYD M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL CREMATION REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>3/28/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ST. JOHN'S</b>	23d. LOCATION (City or Town) (County) (State) <b>HOLLYWOOD, MARYLAND</b>
24. FUNERAL DIRECTOR <b>W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND</b>		25a. REC'D BY REGISTRAR <b>MAR 28 1967</b>	
		25b. REGISTRAR'S SIGNATURE <b>g Charles Judge</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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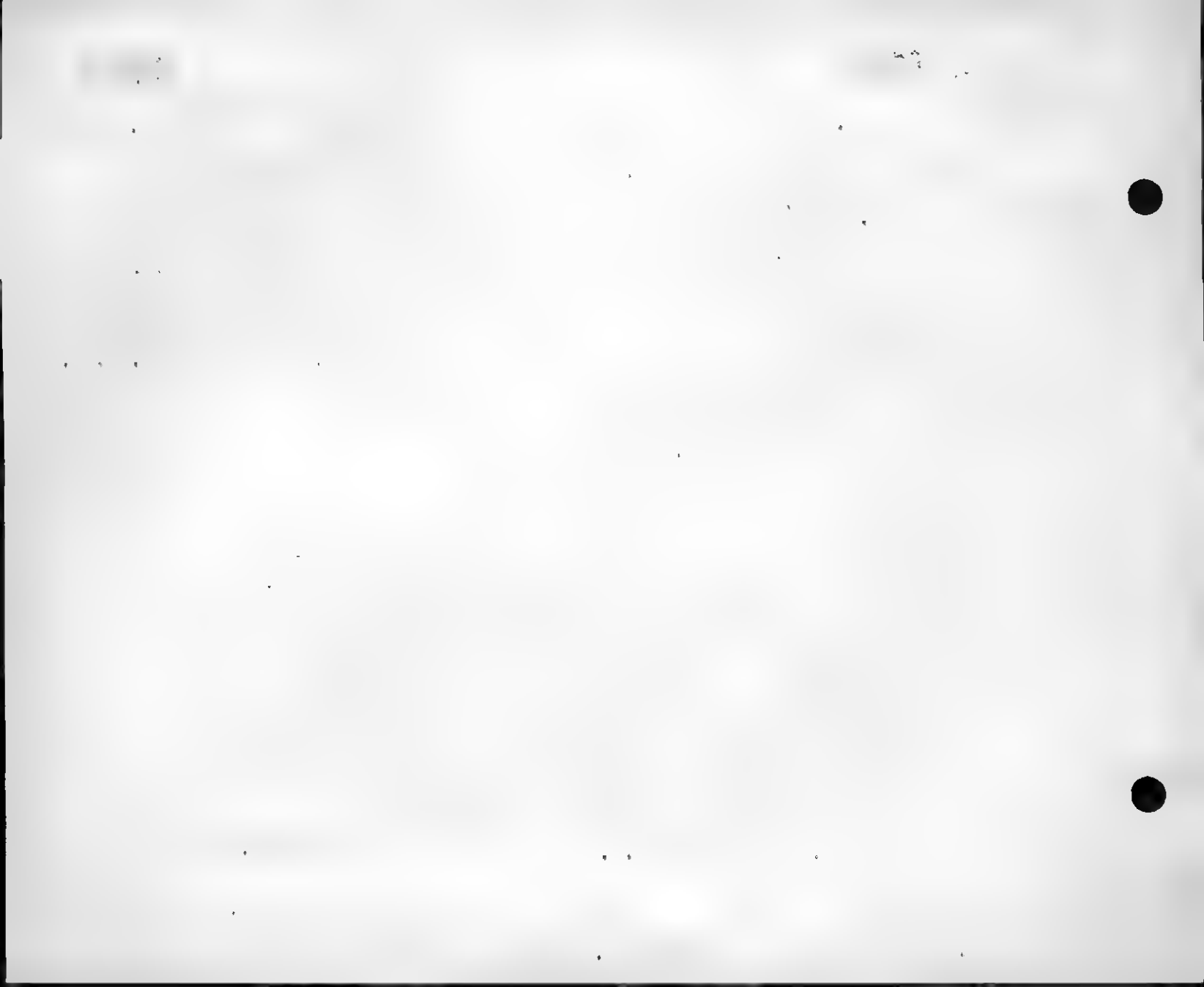
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04200

CERTIFICATE OF DEATH

04199

1 PLACE OF DEATH a. COUNTY <u>St. Mary's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leonardtown</u>		c. LENGTH OF STAY IN TB <u>12 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>St. Mary's Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Herman</u> Last <u>Keenan</u>		4. DATE OF DEATH <u>March</u> 16, 19 <u>67</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 11, 1903</u>
9. AGE (in years last birthday) <u>63</u> yrs		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Nicholas Keenan</u>		14. MOTHER'S MAIDEN NAME <u>Roberta VanWert</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>218-16-0468</u>	
17. INFORMANT <u>Address</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Lung</u> DUE TO (b) <u></u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			INTERVAL BETWEEN ONSET AND DEATH <u>1 yr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1950</u> to <u>March 16, 1967</u> , that (I) (we) last saw the deceased alive on <u>March 16, 1967</u> and that death occurred at <u></u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>J. Roy Guyther</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>J. Roy Guyther, M.D.</u>		22d. ADDRESS <u>Mechanicsville, Maryland</u>	
23a. BURIAL, CREMATION, RE-MOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>3/20/67</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Sacred Heart Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Bushwood, Maryland</u>
24. FUNERAL DIRECTOR <u>W. Clarke Mattingley, Leonardtown, Maryland</u>		25a. REC'D BY REGISTRAR <u>MAR 23 1967</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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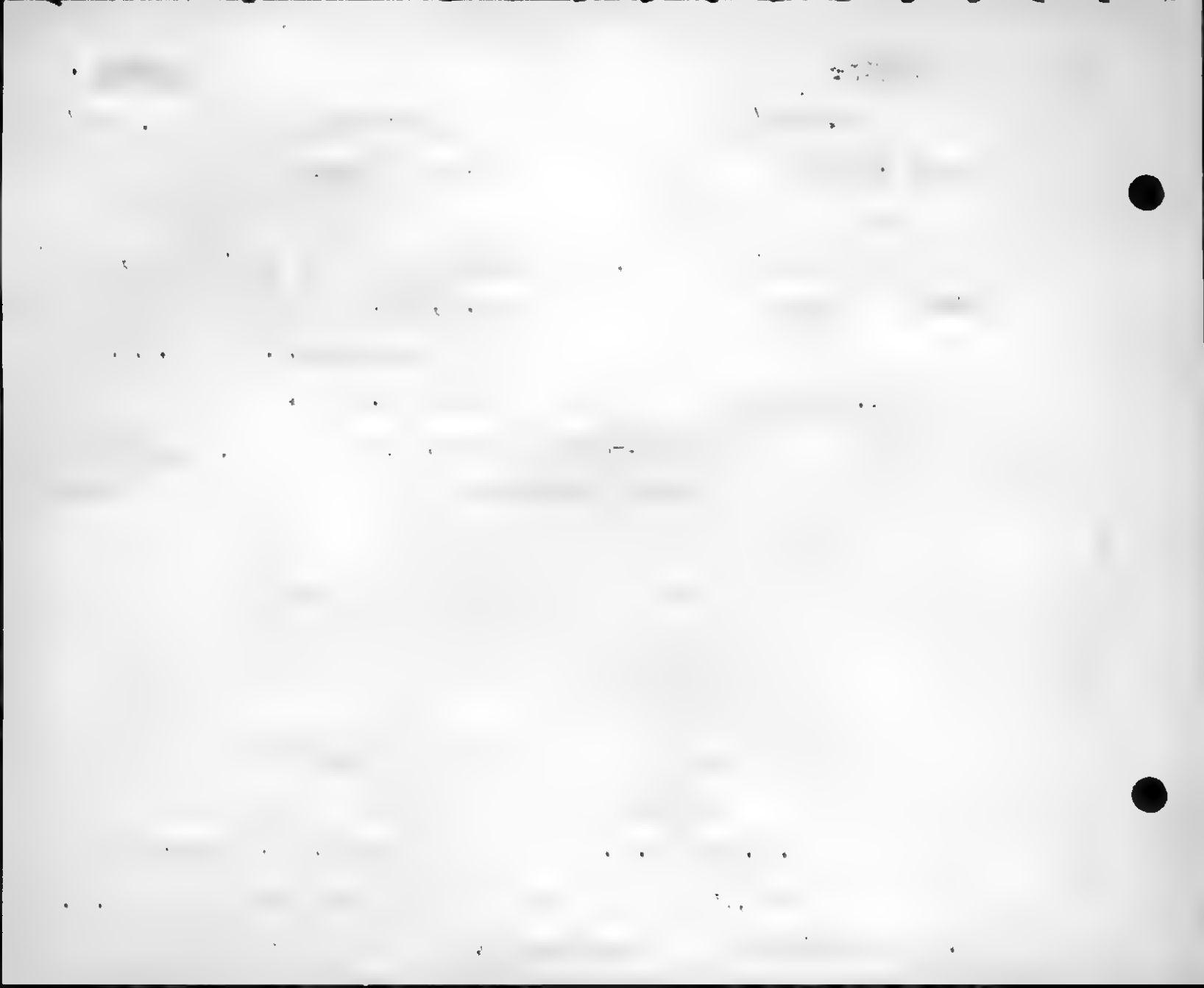
VR A15 (4)  
ZDM 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

04201

04200

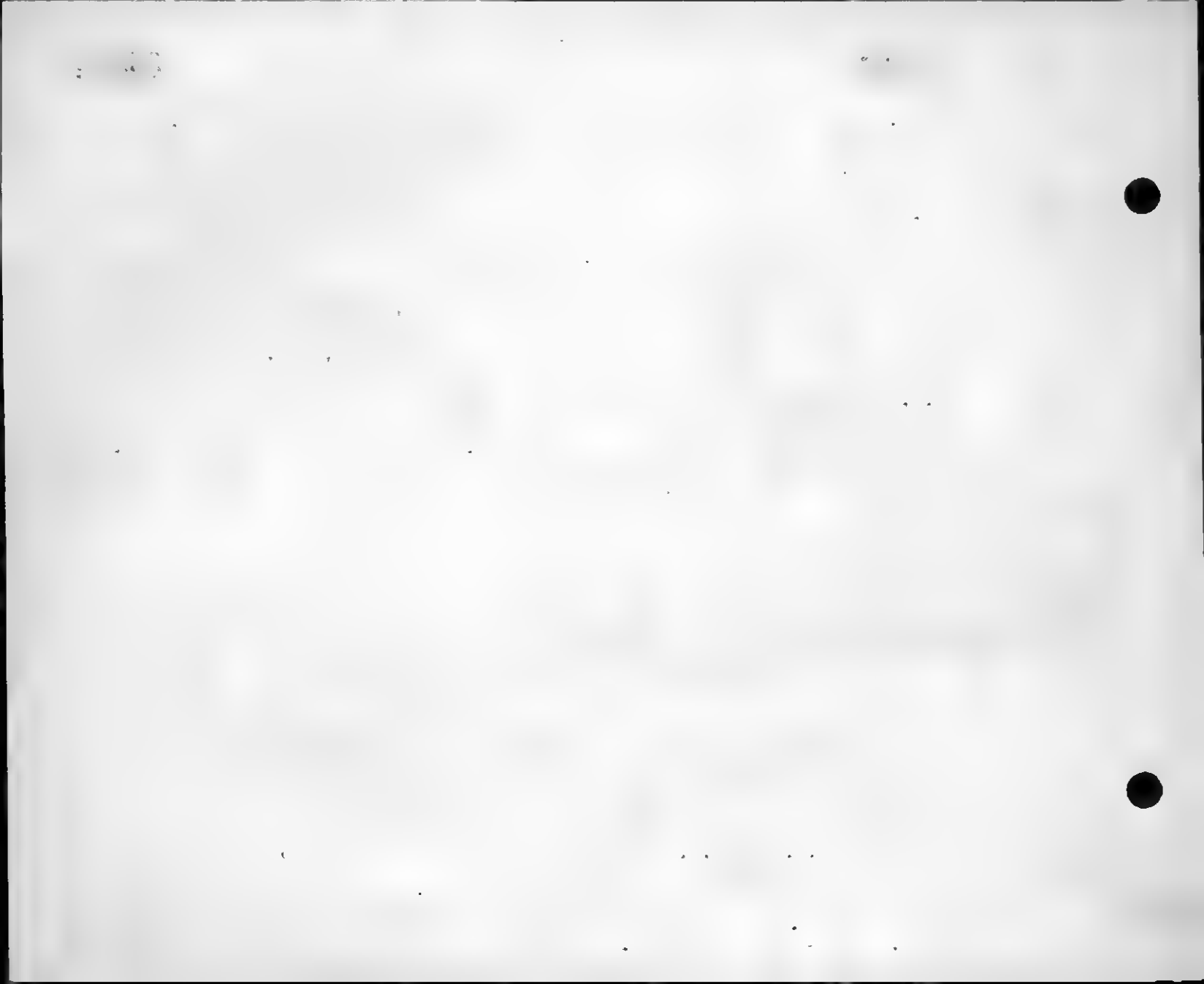
1. PLACE OF DEATH a. COUNTY <u>St. Mary's</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>St. Mary's</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Drayden</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Drayden</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Louise A. Lyon</u>		4. DATE OF DEATH Month Day Year <u>March 2, 1967</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 6, 1901</u>
9. AGE (In years last birthday) <u>65</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11b. KIND OF BUSINESS OR INDUSTRY	
12. BIRTHPLACE (County & State, or foreign country) <u>Washington D.C.</u>		13. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
14. FATHER'S NAME <u>Henry B. Burch</u>		15. MOTHER'S MAIDEN NAME <u>Susie E. Burch</u>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		17. SOCIAL SECURITY NO. <u>217-32-1345B</u>	
18. INFORMANT <u>Joseph A. Lyon</u>		Address <u>Drayden, Maryland</u>	
19. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Myeloma</u> 200X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
21. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
22a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		22b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
22c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		22d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
22e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		22f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May, 1964</u> , to <u>March 2, 1967</u> , that (I) (we) last saw the deceased alive on <u>March 1, 1967</u> , and that death occurred at <u>10:45 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>P. J. Bear</u>		22b. DATE SIGNED <u>3/3/67</u>	
22c. PHYSICIAN'S NAME (Type) <u>P. J. Bear M.D.</u>		22d. ADDRESS <u>Great Mills, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>March 4, 1967</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln</u>	23d. LOCATION (City, town or county) (State) <u>Washington D.C.</u>
24. FUNERAL DIRECTOR <u>W. Clarke Mattingley</u>		25a. REC'D BY REGISTRAR <u>Leonardtown, Md.</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>MAR 6 1967</u>	



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
04202 CERTIFICATE OF DEATH 04201

1. PLACE OF DEATH a. COUNTY <b>ST. MARYS</b> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LEONARDTOWN</b> c. LENGTH OF STAY IN 1b <b>ST. MARYS HOSPITAL</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ST. MARYS</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL HOLLYWOOD</b> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>FLORENCE</b> Middle <b>LEONA</b> Last <b>Mc DANIEL</b>			4. DATE OF DEATH Month <b>MARCH</b> Day <b>7</b> Year <b>1967</b>				
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>APRIL 14, 1883</b>	9. AGE (In years last birthday) <b>83 yrs.</b>	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>DOMESTIC</b>		11. BIRTHPLACE (County & State, or foreign country) <b>ENTERPRISE, MISS.</b>			
13. FATHER'S NAME <b>WM. H. EDMONSON</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>			14. MOTHER'S MAIDEN NAME <b>MARGARET JANE BUCKLEY</b>				
16. SOCIAL SECURITY NO. <b>N/A</b>			17. INFORMANT Address <b>MRS. CLAYTON STROUD - HOLLYWOOD, MD.</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> 411X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Pulmonary embolism; osteoporosis</b>					INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from <b>June 10, 1966</b> , to <b>March 7, 1967</b> , that (I) (we) last saw the deceased alive on <b>March 6, 1967</b> , and that death occurred at <b>10:45 AM</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>P.J. Bean</b> M.D.			22b. DATE SIGNED <b>3/8/67</b>				
22c. PHYSICIAN'S NAME (Type) <b>P.J. BEAN M.D.</b>			22d. ADDRESS <b>GREAT MILLS, MARYLAND</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>3/9/67</b>	23c. NAME OF CEMETERY OR CREMATORY <b>JOY CHAPEL CEMETERY</b>		23d. LOCATION (City, town or county) (State) <b>HOLLYWOOD, MARYLAND</b>			
24. FUNERAL DIRECTOR <b>JOHN M. WELCH - LEONARDTOWN, MD.</b>			25a. REC'D BY REGISTRAR <b>MAR 13 1967</b>				
			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				

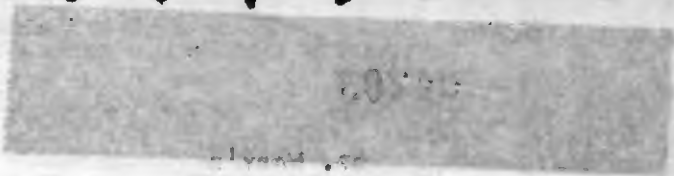


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND									
04203 CERTIFICATE OF DEATH 04202									
1. PLACE OF DEATH a. COUNTY <b>ST. MARY'S</b> <b>MARYLAND</b>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ST. MARY'S</b>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>RURAL MECHANICSVILLE</b>					c. LENGTH OF STAY IN 1b <b>53 YRS.</b>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS <b>ROUTE 5 Box 278</b>				
3. NAME OF DECEASED (Type or print) First <b>DOROTHEA</b> Middle <b>SOPHIE</b> Last <b>STASCH</b>					4. DATE OF DEATH Month <b>MARCH</b> Day <b>24</b> Year <b>1967</b>				
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>MARCH 18, 1890</b>		9. AGE (In years last birthday) <b>77</b> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>AT HOME</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>LU HUI KAUAI, SOUTH AMERICA</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>GULIUS REDIES</b>					14. MOTHER'S MAIDEN NAME <b>ERAUSE</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>					16. SOCIAL SECURITY NO.		17. INFORMANT <b>AUGUST H. STASCH SAME AS # 2 ABOVE</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> 260X DUE TO (b) <b>Atherosclerotic cardiovascular</b> DUE TO (c) <b>Diabetes mellitus</b>								INTERVAL BETWEEN ONSET AND DEATH <b>Instantaneous</b> <b>10 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <b>Jan</b> , 19 <b>48</b> , to <b>Mar 24</b> , 19 <b>67</b> , that (I) (we) last saw the deceased alive on <b>Feb 28, 1967</b> , and that death occurred at <b>10</b> M, from the causes and on the date stated above.									
22a. SIGNATURE <b>J. Roy Guyther</b>					22b. DATE SIGNED				
22c. PHYSICIAN'S NAME (Type) <b>J. ROY GUYTHER M. D.</b>					22d. ADDRESS <b>MECHANICSVILLE, MARYLAND</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>MARCH 27, 1967</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ST PAUL CEMETERY</b>		23d. LOCATION (City, town or county) (State) <b>CHARLOTTE HALL MARYLAND</b>			
24. FUNERAL DIRECTOR <b>W. CLARKE MATTINGLEY LEONARDTOWN, MARYLAND</b>					25a. REC'D BY REGISTRAR <b>MAR 28 1967</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>		

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ST. MARY'S

MARYLAND

ST. MARY'S

ROBAL MICHIGANVILLE

20 YRS.

ROBAL MICHIGANVILLE

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MARCH 1, 1900

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ILLUMINATING

WHITE PAPER

STARCH PAPER

ABOUT 1/2 STARCH DASH AS 1/2 ABOVE

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MICHIGANVILLE, MARYLAND

J. ROY FOTHERS, D.

MARYLAND

CHARLOTTE HALL

MARCH 27, 1901

BRITISH

W. CLARK HATFIELD, LONDON, MARYLAND



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/67

Items 18&21 Film 392 MARYLAND STATE DEPARTMENT OF HEALTH  
9-6-67 ams DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04204

04203

1. PLACE OF DEATH a. COUNTY <b>ST. MARY'S</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>STAR RT. 79B MARYLAND</b> b. COUNTY <b>ST. MARY'S</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LEONARDTOWN, MARYLAND</b>		c. LENGTH OF STAY IN TB <b>ONE DAY</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL LEONARDTOWN</b> 15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>STATION HOSPITAL USNAS PATUXENT RIVER</b>			d. STREET ADDRESS <b>STAR RT. 79B</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>KENNETH</b> Middle <b>THOMAS</b> Last <b>STEELE, JR.</b>			4. DATE OF DEATH Month <b>MARCH</b> Day <b>12</b> Year <b>19 67</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>CAUCASIAN</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEBRUARY 6, 1967</b>		9. AGE (In years last birthday) <b>0 yrs</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>		11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>	
13. FATHER'S NAME <b>KENNETH THOMAS STEELE, SR.</b>			14. MOTHER'S MAIDEN NAME <b>DEBORAH ANN BOYER</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>KENNETH THOMAS STEELE, SR.</b> Address <b>STAR RT 79B</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>754.5</b> IMMEDIATE CAUSE (a) <b>Congenital heart disease</b> DUE TO (b) <b>Terminal pneumonia</b> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>CHILD FOUND IN CRIB WITH CESSATION OF RESPIRATION</b>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>3:35 p.m.</b> <b>MAR 12 19 67</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>HOME</b>	
		20f. (City or town) (County) (State) <b>LEONARDTOWN ST. MARY'S MD.</b>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>William D. Boyd M.D.</i>		EXAMINER'S NAME (Type) <b>WILLIAM D. BOYD M.D.</b>		22. DATE SIGNED <b>3/14/67</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>3/14/67</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NATIONAL</b>	
		23d. LOCATION (City or Town) (County) (State) <b>ARLINGTON VIRGINIA</b>			
24. FUNERAL DIRECTOR <b>W. CLARKE MATTINGLEY</b>		ADDRESS <b>LEONARDTOWN, MARYLAND</b>		25a. REC'D BY REGISTRAR <b>MAR 16 1967</b>	
				25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>	

04303

04303

ST. MARY'S  
ST. MARY'S, THE MARYLAND

LEONARDSON, JAMES  
LEONARDSON, JAMES

STATION HOSPITAL, PATIENT RIVER  
ST. MARY'S, THE

KENNETH  
THOMAS

LEONARDSON, JAMES  
LEONARDSON, JAMES

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LEONARDSON, JAMES

KENNETH THOMAS STEELE, JR.  
KENNETH THOMAS STEELE, JR.

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